

2087

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **209**

FILED JAN 29 1957

 Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 9146 Dischinger Ct</b>		Length of stay in 1b <b>2yr</b>	d. STREET ADDRESS <b>1089 9146 Dischinger Ct</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>M.</b> Last <b>KONITZ</b>			4. DATE OF DEATH Month <b>January</b> Day <b>7th</b> Year <b>1957</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 11th, 1865 91</b>	9. AGE (In years last birthday) <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Bergmann</b>			14. MOTHER'S MAIDEN NAME <b>Fredericka Waldecker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Lydia Goettling, 9146 Dischinger Ct.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>not known</b>
					DUE TO (c) <b>✓</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic nephritis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year			20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>✓</b>		20f. CITY, TOWN, OR LOCATION <b>✓</b>	COUNTY	STATE
21. I attended the deceased from <b>July 5 '57</b> to <b>Jan. 7 '57</b> and last saw her alive on <b>Jan 4 '57</b> Death occurred at <b>1. 015 p m</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. F. Miller</b> (Degree or title) <b>M D</b>			22b. ADDRESS <b>8410 N. Broadway</b>		22c. DATE SIGNED <b>Jan. 8 '57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>1/10/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo</b>	
24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 8 '57</b>	26. REGISTRAR'S SIGNATURE <b>Charles Smith M.D.</b>	

(If licensed Embalmer's Statement on Reverse Side)

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

1. Name of Deceased

2. Date of Death

3. Place of Death

4. Name of Physician

5. Name of Hospital

7881

6. Name of Funeral Home

7. Name of Embalmer

8. Name of Embalmer

9. Name of Embalmer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by ..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J. W. Binkley*

Licensed Embalmer No. *365*

P. O. Address *St. Lau*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.